- ❑ Initiate Waiver services
- ❑ Service Modification
  - ☐ Add a service
  - ☐ Increasing hours of service
  - ☐ Decreasing hours of service
- ❑ Provider Modification (requires 2 ISARs)
- ❑ End a service

MR Waiver Residential Support
Individual Service Authorization Request

CSB _____

CSB provider #

_____

Provider Name _____ Provider Number _____

Name: _____ Start: _____ End: _____

Last, First MI Date Date

Medicaid Number: _____

CHECK SERVICE TO BE PROVIDED ONLY	WEEKLY / YEARLY HOURS	OMR USE
☐ H2014 Supported Living / I n-Home Total # of persons with disabilities living in same residence:_____ ☐ 97535 Congregate (please specify below) Total # of persons with disabilities living in same residence:_____ ☐Group Home ☐Group Home for Children ☐Adult Foster Care Home ☐Assisted Living Facility ☐Sponsored Placement ☐Other:	_____ Hours / week x 52 = _____ Yearly total (1)	
Enter periodic support hours per week if needed—**Do not include in daily hours below**. →	\+ _____ Hours / week =	
Enter total of periodic support hours + regular hours per week →	_____ Hours / week x 52 = _____ Yearly total (2)	

Reason for this request:

Check the allowable activities that are included in the ISP. Indicate the *total* number of hours of program time per day.

	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Training in Functional Skills ☐ personal care and activities of daily living; ☐ use of community resources; ☐ adaptive behavior for home and community environments **Assistance and specialized supervision (excluding nighttime) with** ☐ personal care ☐ activities of daily living, use of community resources ☐ medication, med needs, monitoring health & physical condition ☐ travel to & from training sites and community resources							
☐ **Nighttime Specialized Supervision --** If applicable, indicate hours needed and provide explanation:							
What will staff do for **Nighttime Specialized Supervision**?							
TOTAL DAILY HOURS (Training/Assistance + Nighttime Specialized Supervision)							

ATTACH ADDITIONAL PAGES IF FURTHER EXPLANATION IS NEEDED.

Name of Provider Agency Representative (print) Signature Date

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

CSB Rep/ Case Manager (print) Signature Phone No. Fax No. Date